PENINSULA HEARING, INC
PATIENT INTAKE FORM

Name		Date			
Address		Status	Married Single Divorced Other:______________		
City		State, Zip			
Referred by		Physician		DOB	/ /
Phone		Employed?	Fulltime Partime Retired Student		
Cell phone		e-mail			

HAVE YOU EVER EXPERIENCED: (CIRCLE ONE)	EXPLAIN ANY YES ANSWERS
Dizziness or lightheadedness? Yes No	
Pain or drainage in your ears? Left Right Both	
Ear, head or neck surgery? Yes No Both	
Ear infections? Yes No	
Intolerance to loud sounds? Yes No	
Ringing in your ears? Yes No	
Hearing loss? Left Right Both	
Do your ears feel full or plugged Yes No	

Please list any current medical issues:

Please list any current medications:

HEARING HISTORY		
Have you had your hearing tested before? When?	Yes No	Date:
What were the results?		
Does anyone else in your family have a hearing loss?	Yes No	Who?
Do you currently wear, or have you ever worn, a hearing instrument?	Yes - Left Right Both	No
If yes, what kind?		
Have you ever been exposed to loud noise? If yes, explain?	Yes No	
Why have you chosen to obtain a hearing test now?		

LISTENING SITUATION	**HEARING QUALITY**					**IMPORTANCE TO YOU**				
	Poor				Normal	Not		Somewhat		Very
Quiet	1	2	3	4	5	1	2	3	4	5
Television	1	2	3	4	5	1	2	3	4	5
Restaurants	1	2	3	4	5	1	2	3	4	5
Church	1	2	3	4	5	1	2	3	4	5
Meeting/groups/work	1	2	3	4	5	1	2	3	4	5
Telephone	1	2	3	4	5	1	2	3	4	5
Male voice	1	2	3	4	5	1	2	3	4	5
Female voice	1	2	3	4	5	1	2	3	4	5
Child’s voice	1	2	3	4	5	1	2	3	4	5
Other (list):	1	2	3	4	5	1	2	3	4	5